ORTHODONTIC INSURANCE INFORMATION FORM

Employer Name___________________________________ Phone_______________
Address____
____
Contact____

Insurance Co.____________________________________ Phone_______________
Address____
____
Contact____
Date of Inquiry__________________________ Updated________________________

BENEFITS INFORMATION:

Lifetime Maximum_________________ Yearly Maximum_______________________
Adult Coverage____________________ Dependent Age Limit___________________
Deductible_____________ Ortho Only______ One Time_______ Yearly___________
Payment Percentage____
How is down/monthly benefit determined?__________________________________
Are Payments made - Monthly_______ Qrtly______ Semi-annually_______________
What months determine the end of your quarter?___________________________
Do we submit one time and payments are auto from original claim?____________
Do we submit - Monthly_______ Quarterly________ Otherwise__________________
Do we submit - Coupons______ Claim form______ Verification form____________
Is pre-authorization mandatory?_____________________
If we do not pre-authorize will benefits be paid differently?___________________
Are there any restrictions or limitations on payment?_________________________
Do you accept electronic claims?____________________
What is the “Payer ID#” that is required to process electronic claims?__________

Additional information and limitations:_____________________________________
____
____
____
____
____
____

©Zuelke & Associates, Inc 0500